

NURSING TRANSFER LETTER – INFANT <1yr

Addressograph

INFANT DETAILS		NEXT OF KIN DETAILS			
Name:		Name:			
Address:		Address:			
DOB:		Home Phone No:			
		Mobile No:			
GP	PUBLIC HEALTH NURSE	LOCAL PHARMACY			
Name:	Name:	Name:			
Address:	Address:	Address:			
Phone:	Phone:	Phone:			
REFERRAL DETAILS					
Admission Date:	Transfer Date:	Length of Admission to Date:			
Reason for Referral:					
Referring Consultant:		Receiving Consultant:			
Receiving Hospital:		Phone call to receiving hospital <i>(name of professional spoken to)</i>			
PEWS (Paediatric Early Warning Score): _____ Date: _____ Time: _____					
TREATMENT WHILE IN HOSPITAL					
Reason for admission:					
Diagnosis:					
Medical / Surgical Treatment:		Medical / Surgical History:			
Follow Up Plan & Out Patients Appointments:					
ASSESSMENT AT TIME OF TRANSFER					
Current Problems:					
Significant Previous Problems:					
Current Medications	Dose	Frequency	Route	Last Given	Drug Levels
PHOTOCOPY DRUG KARDEX AND ATTACH TO TRANSFER LETTER					
ALLERGIES					
Allergic to medication: Yes <input type="checkbox"/> No <input type="checkbox"/> Name				Reaction Type	
Allergic to food: Yes <input type="checkbox"/> No <input type="checkbox"/> Name				Reaction Type	
Allergic to plasters / tape: Yes <input type="checkbox"/> No <input type="checkbox"/> Name				Reaction Type	
Other.....					
INFECTIOUS DISEASES					
New Born Screen: Yes <input type="checkbox"/> No <input type="checkbox"/> Repeat due date:..... Newborn Hearing Test: Yes <input type="checkbox"/> No <input type="checkbox"/> When due:.....					

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Immunisations: BCG <input type="checkbox"/> 6:1 <input type="checkbox"/> 1 st / 2 nd / 3 rd (please circle received doses) MMR <input type="checkbox"/> Synagis <input type="checkbox"/> Other <input type="checkbox"/>		
Relevant Family / Social History:		
Parents / Guardian aware of transfer: Yes <input type="checkbox"/> No <input type="checkbox"/>		Interpreter Required: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, language spoken:
CENTRAL / PERIPHERAL ACCESS		
Broviac: Yes <input type="checkbox"/> No <input type="checkbox"/> CVC: Yes <input type="checkbox"/> No <input type="checkbox"/> PICC: Yes <input type="checkbox"/> No <input type="checkbox"/> Insertion site: Insertion date: Priming Volume: Dressing Changed: Last Flushed: Peripheral Cannula: (document site):..... Current IV Infusion: Yes <input type="checkbox"/> No <input type="checkbox"/> Fluids: Rate: Volume: ml/kg/day		
CARDIOVASCULAR SYSTEM		
Pulse / Apex (bpm): Blood Pressure (mmhg): CRT: Time:		
RESPIRATORY		
Colour: Respirations (bpm): Signs of increased work of breathing: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes: (document signs) Sound: (Stridor/G grunt/Wheeze/None):..... Nursed on: Room air/O ₂ therapy via O₂ – How many litres: CPAP: <input type="checkbox"/> BIPAP: <input type="checkbox"/> Pressure: <input type="checkbox"/> No: Tracheostomy Tube: Yes <input type="checkbox"/> No <input type="checkbox"/> Nasopharyngeal Airway: Yes <input type="checkbox"/> No <input type="checkbox"/> Type:.....Size:..... Suction Catheter Size: Depth: Last tube change date: Nursed on apnoea monitor / O₂ sats monitor: Yes <input type="checkbox"/> No <input type="checkbox"/> SpO₂: %		
NEUROLOGICAL SYSTEM		
Glasgow Coma Scale: <input type="checkbox"/> Value: Level of Consciousness (AVPU): Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresponsive <input type="checkbox"/>		
CONTROLLING BODY TEMPERATURE		
Peripheral Temperature: °C Incubator: Yes <input type="checkbox"/> No <input type="checkbox"/> Incubator Temperature:		
NUTRITION		
Admission Weight: kg Date: Discharge Weight: kg Date: SLT/Dietician: Regime given to Parent/Guardian: Yes <input type="checkbox"/> No <input type="checkbox"/> Feed Type: Breast Milk <input type="checkbox"/> With Additions <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Formula <input type="checkbox"/> Type:..... Volume:..... mls Frequency:..... Mls/Kg:..... Feeding: NPO <input type="checkbox"/> PO <input type="checkbox"/> Ng <input type="checkbox"/> Peg <input type="checkbox"/> NJ <input type="checkbox"/> Other Tube size: Last Changed:		
ELIMINATION		
Urine: Per Urethra <input type="checkbox"/> Urinary Catheter <input type="checkbox"/> Other:..... Last passed urine at Strict Intake / Output: Yes <input type="checkbox"/> No <input type="checkbox"/> ml/kg/hr Bowels: Per rectum <input type="checkbox"/> Ileostomy <input type="checkbox"/> Colostomy <input type="checkbox"/> Last motion: Usual Pattern: Additional information re: Stoma Care / Anal Dilatations / Washouts: Drains: Chest <input type="checkbox"/> Penrose <input type="checkbox"/> Redivac <input type="checkbox"/> Other:..... Date for removal: N/G Free Drainage: Yes <input type="checkbox"/> No <input type="checkbox"/> ml Aspirate: Yes <input type="checkbox"/> No <input type="checkbox"/> Hourly: Yes <input type="checkbox"/> No <input type="checkbox"/> Other: Replacing Losses: Yes <input type="checkbox"/> No <input type="checkbox"/> Fluids Used:		
PERSONAL CLEANSING		
Umbilicus: Umbilical Cord Clamp: Eyes: Mouth: Buttock: Wound Location: Wound Appearance: Sutures <input type="checkbox"/> Steristrips <input type="checkbox"/> Dressing <input type="checkbox"/> Date for Removal: Dressing Change:		
PAIN	PLAY	ADDITIONAL INFORMATION
Analgesia Required: Yes <input type="checkbox"/> No <input type="checkbox"/> Last Given: Drug Name: Dose:	Soother / Blanket / Comforter: Yes <input type="checkbox"/> No <input type="checkbox"/> Detail:	Religion: Ethnicity: Baptised: Yes <input type="checkbox"/> No <input type="checkbox"/>

Signature: _____ CNM I / II / SN NMBI _____ Ward _____ Date: _____